

		FOR OHF USE					

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2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0029595</div> <div>Facility Name: THORNTON HEIGHTS TERRACE</div> <div>Address: 106 WEST 10TH STREET CHICAGO HEIGHTS 60411</div> <div>County: COOK</div> <div>Telephone Number: (708) 754-2220 Fax # (708) 754-9311</div> <div>IDPA ID Number: 363304964001</div> <div>Date of Initial License for Current Owners: 12/18/95</div> <div>Type of Ownership:</div> <div><div><div>VOLUNTARY,NON-PROFIT</div><div><div>Charitable Corp.</div><div>Trust</div></div><div>IRS Exemption Code</div></div><div><div>X PROPRIETARY</div><div><div>Individual</div><div>Partnership</div><div>Corporation</div><div>X "Sub-S" Corp.</div><div>Limited Liability Co.</div><div>Trust</div><div>Other</div></div><div><div>GOVERNMENTAL</div><div><div>State</div><div>County</div><div>Other</div></div></div></div><div><div>In the event there are further questions about this report, please contact:</div><div>Name: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed) (Date)</div><div>(Type or Print Name)</div><div>(Title)</div></div> <div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached (Date)</div><div>(Print Name and Title) RICHARD S. SGARLATA, C.P.A.</div><div>(Firm Name &amp; Address) Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax# (847) 236-1155</div><div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div>
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Facility Name & ID Number THORNTON HEIGHTS TERRACE

# 0029595 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1		Skilled (SNF)		1
2		Skilled Pediatric (SNF/PED)		2
3	222	Intermediate (ICF)	222	81,030
4		Intermediate/DD		4
5		Sheltered Care (SC)		5
6		ICF/DD 16 or Less		6
7	222	TOTALS	222	81,030

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8	SNF				8
9	SNF/PED				9
10	ICF	76,050	1,119	77,169	10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	76,050	1,119	77,169	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.24%

D. How many bed-hold days during this year were paid by Public Aid? 3054 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 6/1/84

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 6/1/84 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☐ NO ☒ If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **THORNTON HEIGHTS TERRACE** # **0029595** Report Period Beginning: **01/01/01** Ending: **12/31/01**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	220,584	32,429	11,400	264,413		264,413		264,413			1
2	Food Purchase		323,732		323,732	(14,564)	309,169	(47)	309,122			2
3	Housekeeping	179,046	42,668		221,714		221,714		221,714			3
4	Laundry	16,633	7,859		24,492		24,492		24,492			4
5	Heat and Other Utilities			159,780	159,780		159,780	1,360	161,140			5
6	Maintenance	96,656		72,195	168,851		168,851	2,033	170,884			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	512,919	406,688	243,375	1,162,982	(14,564)	1,148,419	3,346	1,151,765			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			2,700	2,700		2,700		2,700			9
10	Nursing and Medical Records	1,130,474	25,977	1,800	1,158,251		1,158,251		1,158,251			10
10a	Therapy			561	561		561		561			10a
11	Activities	79,790	15,948	4,521	100,259		100,259		100,259			11
12	Social Services	345,362		20,823	366,185		366,185		366,185			12
13	Nurse Aide Training											13
14	Program Transportation			1,617	1,617		1,617		1,617			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,555,626	41,925	32,022	1,629,573		1,629,573		1,629,573			16
	<b>C. General Administration</b>											
17	Administrative	435,966		744,545	1,180,511		1,180,511	(286,499)	894,012			17
18	Directors Fees			90,000	90,000		90,000	(54,000)	36,000			18
19	Professional Services			35,517	35,517		35,517	(14,488)	21,029			19
20	Dues, Fees, Subscriptions & Promotions			36,638	36,638		36,638	(18,057)	18,581			20
21	Clerical & General Office Expenses	399,702	31,511	36,778	467,991		467,991	(144,317)	323,674			21
22	Employee Benefits & Payroll Taxes			497,396	497,396	14,564	511,960		511,960			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,730	1,730		1,730		1,730			24
25	Other Admin. Staff Transportation			1,985	1,985		1,985		1,985			25
26	Insurance-Prop.Liab.Malpractice			73,178	73,178		73,178	106	73,284			26
27	Other (specify):*							4,582	4,582			27
28	<b>TOTAL General Administration</b>	835,668	31,511	1,517,767	2,384,946	14,564	2,399,510	(512,673)	1,886,837			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,904,213	480,124	1,793,164	5,177,501		5,177,501	(509,326)	4,668,175			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38,804	38,804		38,804	207,860	246,664			30
31	Amortization of Pre-Op. & Org.							52,283	52,283			31
32	Interest							168,002	168,002			32
33	Real Estate Taxes			385,825	385,825		385,825	4,807	390,632			33
34	Rent-Facility & Grounds			927,022	927,022		927,022	(912,513)	14,509			34
35	Rent-Equipment & Vehicles			25,330	25,330		25,330		25,330			35
36	Other (specify):*											36
37	TOTAL Ownership			1,376,981	1,376,981		1,376,981	(479,561)	897,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,545	121,545		121,545		121,545			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			121,545	121,545		121,545		121,545			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,904,213	480,124	3,291,690	6,676,027		6,676,027	(988,887)	5,687,140			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	81,438	30		9
10	Interest and Other Investment Income	(45,583)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20)	21		18
19	Entertainment	(5,079)	20		19
20	Contributions	(7,514)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,023)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(233,208)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (223,036)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(765,852)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (765,852)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (988,887)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
	Reference		
1 Non-Care Depreciation	30	\$ (18,503)	1
2 Miscellaneous income	21	(152)	2
3 Illinois Council COPE	20	(4,569)	3
4 Non-allowable accounting expenses (Barton)	19	(526)	4
5 Professional fees-Tamarack Care Advisors	19	(8,333)	5
6 Non-allowable directors' fees	18	(54,000)	6
7 Non-allowable salary	21	(30,000)	7
8 Non-allowable salary	21	(25,000)	8
9 Bank charges	21	(150)	9
10 Non-allowable salary	21	(37,500)	10
11 Non-allowable salary	21	(45,000)	11
12 Phone commissions	21	(869)	12
13 Barton allocation-marketing	20	(939)	13
14 Non-allowable accounting fees (Bldg co.)	19	(975)	14
15 Non-allowable legal (Bldg co.)	19	(350)	15
16 Bldg company state replacement tax	19	(6,342)	16
17			17
18			18
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22			22
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91			91

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number THORNTON HEIGHTS TERRACE

# 0029595

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(47)											(47)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,360									1,360	5
6	Maintenance			2,033									2,033	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	(47)		3,393									3,346	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													16
	<b>C. General Administration</b>													
17	Administrative					(286,499)							(286,499)	17
18	Directors Fees	(54,000)											(54,000)	18
19	Professional Services	(16,526)	1,325		713								(14,488)	19
20	Fees, Subscriptions & Promotions	(18,101)			44								(18,057)	20
21	Clerical & General Office Expenses	(151,714)	6,342	645	410								(144,317)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			106									106	26
27	Other (specify):*			1,506		3,076							4,582	27
28	<b>TOTAL General Administration</b>	(240,341)	7,667	2,257	1,167	(283,423)							(512,673)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(240,388)	7,667	5,650	1,167	(283,423)							(509,326)	29

## Summary B

<b>Facility Name &amp; ID Number</b>	<b>THORNTON HEIGHTS TERRACE</b>	<b>#</b>	<b>0029595</b>	<b>Report Period Beginning:</b>	<b>01/01/01</b>	<b>Ending:</b>	<b>12/31/01</b>
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**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
30	Depreciation	62,935	144,925										207,860	30
31	Amortization of Pre-Op. & Org.		52,283										52,283	31
32	Interest	(45,583)	195,948		17,637								168,002	32
33	Real Estate Taxes			4,807									4,807	33
34	Rent-Facility & Grounds		(893,772)	(18,741)									(912,513)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	17,352	(500,616)	(13,934)	17,637								(479,561)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(223,036)	(492,949)	(8,284)	18,804	(283,423)							(988,887)	45



## VII. RELATED PARTIES

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

[illegible]

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ **X** YES ☐ NO

**If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.**

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental income	\$ 893,772	Thornton Heights Associates	100.00%	\$	\$ (893,772)	1
2	V	32	Interest income	54,445	Thornton Heights Associates	100.00%		(54,445)	2
3	V	19	Accounting fees		Thornton Heights Associates	100.00%	975	975	3
4	V	19	Legal fees		Thornton Heights Associates	100.00%	350	350	4
5	V	31	Amortization-Loan costs		Thornton Heights Associates	100.00%	52,283	52,283	5
6	V	30	Depreciation		Thornton Heights Associates	100.00%	144,925	144,925	6
7	V	21	Replacement taxes		Thornton Heights Associates	100.00%	6,342	6,342	7
8	V	32	Interest expense		Thornton Heights Associates	100.00%	250,393	250,393	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 948,217			\$ 455,268	\$ * (492,949)	14

**\* Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 1,360	\$ 1,360	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		2,033	2,033	16
17	V	21	CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		645	645	17
18	V	26	INSURANCE		BARTON MANAGEMENT INC.		106	106	18
19	V	27	EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		1,506	1,506	19
20	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.		4,807	4,807	20
21	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.		14,509	14,509	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	33,250	BARTON MANAGEMENT INC.			(33,250)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 33,250			\$ 24,966	\$ * (8,284)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	BARTON HEALTHCARE LLC	100.00%	\$ 713	\$ 713	15
16	V	20	DUES, SUBSCRIPTIONS		BARTON HEALTHCARE LLC		44	44	16
17	V	21	CLERICAL		BARTON HEALTHCARE LLC		410	410	17
18	V	32	INTEREST		BARTON HEALTHCARE LLC		268,030	268,030	18
19	V								19
20	V								20
21	V	32	INTEREST	250,393	BARTON HEALTHCARE LLC			(250,393)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 250,393			\$ 269,197	\$ * 18,804	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$	REDWOOD MANAGEMENT	100.00%	\$	\$	15
16	V								16
17	V	17	MANAGEMENT FEES	372,179				(372,179)	17
18	V								18
19	V	17	SALARY-L.SHLOFROCK				85,680	85,680	19
20	V	27	PAYROLL TAXES-LS				3,076	3,076	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 372,179			\$ 88,756	\$ * (283,423)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number      **THORNTON HEIGHTS TERRACE**      #      **0029595**      Report Period Beginning:      **01/01/01**      Ending:      **12/31/01**

**VII. RELATED PARTIES (continued)**

**C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.**

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Leon Shlofrock	Shareholder	Administrative	21.56%	See attached	9	18.00%	Alloc. Salary	\$ 85,680	17-7	1
2	John Shlofrock	Shareholder	Administrative	0.33%	See attached	5	11.00%	Facility	46,500	17-1	2
3	Elisa Shlofrock-Zusman	Shareholder	Clerical	0.33%	See attached	6	15.00%	Facility	40,559	21-1	3
4	Marla Coquillet	Shareholder	Administrative	9.87%	See attached	15	33.00%	Facility	67,380	17-1	4
5	Jean Shlofrock	Relative	Clerical	0.00%	See attached	5	12.50%	Facility	18,417	21-1	5
6	Rick Duros	Shareholder	Administrative	0.33%	See attached	7	16.00%	Facility	38,644	17-1	6
7	Gary Weintraub	Shareholder	Legal	9.87%	See attached	6	15.00%	Facility	74,066	17-1	7
8	Melvin Siegel	Shareholder	Administrative	9.48%	See attached	6	8.00%	Alloc. Salary	186,230	17-7	8
9	Martin Weiss	Shareholder	Administrative	1.50%	See attached	6	10.00%	Alloc. Salary	186,136	17-7	9
10	Melvin Siegel	Shareholder	Administrative	9.48%	See attached	6	8.00%	Director fees	18,000	18-3	10
11	Martin Weiss	Shareholder	Administrative	1.50%	See attached	6	10.00%	Director fees	18,000	18-3	11
12											12
13								TOTAL	\$ 779,612		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THORNTON HEIGHTS TERRACE # 0029595 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**Ending: 12/31/01**

(847) 441-0800

Facility Name & ID Number THORNTON HEIGHTS TERRACE# 0029595

Report Period Beginning:

01/01/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

BARTON HEALTHCARE LLC

Street Address

465 CENTRAL AVE.

City / State / Zip Code

NORTHFIELD, IL 60093

Phone Number

( 847) 441-8200

Fax Number

( 847) 441-0800

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	29	7	\$ 3,225	\$	5	\$ 713	1
2	20	DUES, SUBSCRIPTIONS	NOTE RECEIVABLE	29	7	200		5	44	2
3	21	CLERICAL	NOTE RECEIVABLE	29	7	1,855		5	410	3
4	32	INTEREST	NOTE RECEIVABLE	29	7	1,212,319		5	268,030	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,217,599	\$		\$ 269,197	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE# 0029595

Report Period Beginning:

01/01/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

REDWOOD MANAGEMENT

Street Address

465 CENTRAL AVE. ,SUITE 100

City / State / Zip Code

NORTHFIELD, IL. 60093

Phone Number

( 847) 441-8200

Fax Number

( 847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	\$ 675	\$			1
2										2
3										3
4										4
5	17	SALARY-L.SHLOFROCK	AVG HOURS WORKED	25	5	238,000	238,000	9	85,680	5
6	27	PAYROLL TAXES-LS	AVG HOURS WORKED	25	5	8,546		9	3,076	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 247,221	\$ 238,000		\$ 88,756	25

**Ending: 12/31/01**

**Fax Number**



Facility Name & ID Number THORNTON HEIGHTS TERRACE # 0029595 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE # 0029595 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE # 0029595 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE # 0029595 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**Ending: 12/31/01**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Barton Healthcare	X		Mortgage	\$27,803	1/27/95	\$ 6,500,000	\$ 4,225,028	01/20/15		\$ 268,030	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$27,803		\$ 6,500,000	\$ 4,225,028			\$ 268,030	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule											10	
11												11	
12	Interest Income	X		Thornton Heights Terrace							(45,583)	12	
13	Interest Income	X		Thornton Heights Associates							(54,445)	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (100,028)	14	
15	TOTALS (line 9+line14)						\$ 6,500,000	\$ 4,225,028			\$ 168,002	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)  
\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							\$				\$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$				\$	21





IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

THORNTON HEIGHTS TERRACE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0029595

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 32-20-205-011	Long term care property	\$ 382,106.29	\$ 382,106.29
2. Barton Management Allocation	See attached	\$ 60,183.77	\$ 4,807.01
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 442,290.06	\$ 386,913.30

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?   X       YES       NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,085

B. General Construction Type: ExteriorFrameNumber of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).  
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  
If so, please complete the following:

1. Total Amount Incurred: 435,383

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 52,283

4. Dates Incurred: 1995-1998

Nature of Costs:  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 266,529	1
2					2
3	TOTALS			\$ 266,529	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1991	\$ 3,982,306	\$ 126,422	35	\$ 199,115	\$ 72,693	\$ 1,924,778	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	5,767		20	-		5,767	9
10	Various			1981	13,000		20	520	520	11,700	10
11	Various			1985	7,018		20	60	60	6,508	11
12	Various			1986	13,102		20	531	(531)	9,971	12
13	Various			1987	899		20	45	45	675	13
14	Various			1989	9,106		20	455	455	4,934	14
15	Various			1990	4,093		20	179	179	2,264	15
16	Various			1991	24,882		20	918	918	9,532	16
17	Various			1992	10,189		20	969	969	8,109	17
18	Various			1993	80,557		20	4,438	4,438	36,256	18
19	Various			1994	75,510		20	3,777	3,777	28,980	19
20	Various			1995	56,341		20	2,816	2,816	18,953	20
21	Various			1996	27,338		20	1,368	1,368	7,495	21
22	Various			1997	33,349		20	1,669	1,669	7,636	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



Facility Name &amp; ID Number THORNTON HEIGHTS TERRACE

# 0029595

Report Period Beginning:

01/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,343,457	\$ 143,038		\$ 216,860	\$ 73,822	\$ 2,083,558	1
2	<u>DOORS</u>	1998	858		20	43	43	172	2
3	<u>HEATER PUMP</u>	1998	2,887		20	144	144	552	3
4	<u>EMERG PANEL</u>	1998	1,650		20	83	83	311	4
5	<u>FLOOR TILE</u>	1998	4,900		20	245	245	919	5
6	<u>EPOXY FLOORING</u>	1998	1,975		20	99	99	363	6
7	<u>BOILER FIREBOX</u>	1998	3,602		20	180	180	645	7
8	<u>AIR CLEANER</u>	1998	1,894		20	95	95	340	8
9	<u>RENOVATE ELEVATORS</u>	1998	10,640		20	532	532	1,862	9
10	<u>SUMP PUMP</u>	1998	2,550		20	128	128	448	10
11	<u>WINDOW</u>	1998	1,885		20	94	94	313	11
12	<u>BATHROOM FIXTURES</u>	1998	532		20	27	27	90	12
13	<u>SILVER COAT ROOF</u>	1998	4,700		20	235	235	764	13
14	<u>CURTAINS</u>	1998	1,763		20	88	88	279	14
15	<u>FLOORING</u>	1998	5,950		20	298	298	919	15
16	<u>BOILER HEAT BUNDLE</u>	1998	5,225		20	261	261	805	16
17	<u>BOILER REPAIRS</u>	1998	959		20	48	48	148	17
18	<u>LIGHT FIXTURES</u>	1998	823		20	41	41	126	18
19	<u>DOORS</u>	1999	1,108		20	55	55	160	19
20	<u>PANELS</u>	1999	1,548		20	77	77	218	20
21	<u>LIGHT FIXTURES</u>	1999	735		20	37	37	105	21
22	<u>CUBICLE CURTAINS</u>	1999	1,214		20	61	61	168	22
23	<u>ROOFTOP CHILLER</u>	1999	638		20	32	32	85	23
24	<u>TILE &amp; COVE BASE</u>	1999	1,000		20	50	50	133	24
25	<u>ROOF EXHAUSTER</u>	1999	600		20	30	30	78	25
26	<u>RENOVATE ELEVATOR</u>	1999	14,200		20	710	710	1,775	26
27	<u>TUCKPOINTING</u>	1999	2,235		20	112	112	280	27
28	<u>RENOVATION</u>	1999	40,000		20	2,000	2,000	4,833	28
29	<u>SEALCOAT DRIVE &amp; LOT</u>	1999	3,430		20	172	172	416	29
30	<u>DOOR HOLDERS</u>	1999	1,485		20	74	74	173	30
31	<u>REPAIR SPRINKLER SYS</u>	1999	1,238		20	62	62	140	31
32	<u>TILE FLOORS</u>	1999	5,400		20	270	270	608	32
33	<u>FIRE DAMPER</u>	1999	1,880		20	94	94	204	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,472,961	\$ 143,038		\$ 223,337	\$ 80,299	\$ 2,101,990	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,472,961	\$ 143,038		\$ 223,337	\$ 80,299	\$ 2,101,990	1
2	INSTALL TILE	1999	5,550		20	278	278	579	2
3	LIGHT FIXTURES	1999	1,123		20	56	56	117	3
4	RAMP HANDRAIL	1999	660		20	33	33	69	4
5	FENCE	2000	2,990		20	150	150	275	5
6	AIR CLEANERS (2)	2000	3,800		20	190	190	333	6
7	CUBICLE CURTAINS	2000	736		20	37	37	65	7
8	WALL PANELS	2000	4,656		20	233	233	369	8
9	WALL PANELS	2000	1,129		20	56	56	84	9
10	ELECTRICAL PANELS	2000	1,695		20	85	85	113	10
11	GRAVEL	2000	900		20	45	45	56	11
12	FLOOR TILE	2000	900		20	45	45	56	12
13	NURSING STATION WALL	2000	2,074		20	104	104	121	13
14	DOORS	2000	3,053		20	153	153	179	14
15	RENOVATION	2000	11,540		20	577	577	625	15
16	FIRE ALARM SYSTEM	2001	4,926		20	110	110	110	16
17	A/C UNIT-INSTALL	2001	69,785		20	1,565	1,565	1,565	17
18	BEDROOM WINDOWS	2001	800		20	17	17	17	18
19	CURTAINS	2001	2,316		20	47	47	47	19
20	DRYWALL	2001	717		20	13	13	13	20
21	ROOF REPAIRS & COATI	2001	6,825		20	109	109	109	21
22	A/C UNIT INSTALL	2001	3,600		20	58	58	58	22
23	A/C UNIT-WARRANTY	2001	6,800		20	109	109	109	23
24	ROOM WINDOWS	2001	1,000		20	16	16	16	24
25	MAGNETIC DOOR CLOSER	2001	1,375		20	19	19	19	25
26	DOORS	2001	3,121		20	37	37	37	26
27	FIRE ALARM SYSTEM	2001	3,334		20	39	39	39	27
28	A/C UNIT WORK	2001	26,860		20	316	316	316	28
29	REMODELING KITCHEN	2001	3,100		20	30	30	30	29
30	SHOWER/TUB WORK	2001	6,710		20	50	50	50	30
31	PANELS	2001	1,334		20	10	10	10	31
32	PLUMBING WORK-KITCHE	2001	1,160		20	6	6	6	32
33	PLUMBING WORK-KITCHN	2001	740		20	1	1	1	33
34	TOTAL (lines 1 thru 33)		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$4,658,270	\$143,038		\$227,931	\$84,893	\$2,107,583	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,658,270	\$143,038		\$227,931	\$84,893	\$2,107,583	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,658,270	\$ 143,038		\$ 227,931	\$ 84,893	\$ 2,107,583	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$164,104	\$20,169	\$14,511	\$(5,658)	10	\$88,653	71
72	Current Year Purchases	14,912		2,203	2,203	10	2,203	72
73	Fully Depreciated Assets	334,429				10	334,429	73
74								74
75	TOTALS	\$513,445	\$20,169	\$16,714	\$(3,455)		\$425,285	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1998 FORD VAN	2001	\$13,217	\$2,019	\$661	\$(1,358)	5	\$661	76
77	Facility	2002 FORD XL WAGON	2001	27,163		1,358	1,358	5	1,358	77
78										78
79										79
80	TOTALS			\$40,380	\$2,019	\$2,019			\$2,019	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,478,624	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$165,226	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$246,664	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$81,438	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,534,887	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BUILDING - 1996	\$480,000	\$12,308	\$63,079	86
87	BUILDING - 1998	241,623	6,195	21,941	87
88	LAND - 1996	53,349			88
89	LAND - 1998	26,847			89
90					90
91	TOTALS	\$801,819	\$18,503	\$85,020	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

[illegible]





A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,155,951	\$ 1,254,692	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,467,002	1,467,002	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		1,370,000	5
6	Prepaid Insurance	44,514	44,514	6
7	Other Prepaid Expenses	2,909	2,909	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,670,376	\$ 4,139,117	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		346,725	13
14	Buildings, at Historical Cost		4,703,929	14
15	Leasehold Improvements, at Historical Cost	657,260	657,260	15
16	Equipment, at Historical Cost	336,844	552,478	16
17	Accumulated Depreciation (book methods)	(376,978)	(2,052,471)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		116,373	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 617,126	\$ 4,324,294	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,287,502	\$ 8,463,411	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 79,826	\$ 79,825	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,662	72,662	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,454	4,454	31
32	Accrued Real Estate Taxes(Sch.IX-B)	393,569	393,569	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See supplemental schedule		10,665	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 550,511	\$ 561,175	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,225,028	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See supplemental schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,225,028	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 550,511	\$ 4,786,203	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,736,991	\$ 3,677,208	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,287,502	\$ 8,463,411	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,999,096	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,999,096	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	837,895	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 737,895	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,736,991	24 *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number THORNTON HEIGHTS TERRACE

# 0029595

Report Period Beginning: 01/01/01

Ending:

12/31/01

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,462,104	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,462,104	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	50,797	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 50,797	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See supplemental schedule	1,021	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,021	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,513,922	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,162,982	31
32	Health Care	1,629,573	32
33	General Administration	2,384,946	33
	<b>B. Capital Expense</b>		
34	Ownership	1,376,981	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	121,545	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,676,027	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	837,895	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 837,895	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number THORNTON HEIGHTS TERRACE# 0029595

Report Period Beginning:

01/01/01

Ending:

12/31/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 59,950	\$ 28.82	1
2	Assistant Director of Nursing	1,040	1,177	25,514	21.68	2
3	Registered Nurses	8,592	9,339	193,700	20.74	3
4	Licensed Practical Nurses	14,905	16,873	291,402	17.27	4
5	Nurse Aides & Orderlies	60,487	66,407	544,425	8.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,741	9,715	79,790	8.21	10
11	Social Service Workers	24,220	27,322	345,362	12.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,082	23,528	220,584	9.38	15
16	Dishwashers					16
17	Maintenance Workers	8,955	10,121	96,656	9.55	17
18	Housekeepers	20,567	22,841	179,046	7.84	18
19	Laundry	2,172	2,386	16,633	6.97	19
20	Administrator	2,000	2,080	87,351	42.00	20
21	Assistant Administrator	2,828	2,964	68,805	23.21	21
22	Other Administrative	4,995	5,429	279,810	51.54	22
23	Office Manager					23
24	Clerical	42,973	46,208	399,702	8.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,568	1,985	15,483	7.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	227,125	250,455	\$ 2,904,213 *	\$ 11.60	34

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	285	\$ 11,400	01-03	35
36	Medical Director	117	2,700	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	12	561	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	159	4,521	11-03	44
45	Social Service Consultant	416	20,823	12-03	45
46	Other(specify)				46
47	Fire safety consultant	96	1,800	06-03	47
48					48
49	TOTAL (lines 35 - 48)	1,181	\$ 43,605		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Elfie Cull (1/1-12/31/01)	Administrator	0	\$ 87,351	Workers' Compensation Insurance	\$	66,889	IDPH License Fee	\$ 400	
Steve Bachand (1/1-12/31/01)	Asst. Administrator	0	49,024	Unemployment Compensation Insurance		11,577	Advertising: Employee Recruitment		
Diane Logan (1/1-12/31/01)	Asst. Administrator	0	19,781	FICA Taxes		198,300	Health Care Worker Background Check	466	
See attached schedule	Administrative	0	279,810	Employee Health Insurance		174,050	(Indicate # of checks performed <u>67</u> )		
				Employee Meals		14,564	Licenses and fees	368	
				Illinois Municipal Retirement Fund (IMRF)*		1,047	Dues and subscriptions	4,667	
				Union pension contribution		24,778	Dues-ICLTC	8,543	
				Employee benefits		8,145	Classified advertising	4,093	
				Christmas expense		12,610	Barton Management allocation	44	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 435,966						
B. Administrative - Other									
Description			Amount						
Redwood Management			\$ 372,179						
Melvin Siegel			186,230						
Martin Weiss			186,136						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 744,545						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Frost Ruttenberg & Rothblatt	Accounting	\$	8,770			\$	Out-of-State Travel	\$	
Pension Performance	Accounting		5,815						
Barton Management-Allocation	Accounting		526						
Mayer, Brown and Platt	Legal		2,181				In-State Travel		
Jerry Brown	Legal		50						
Tamarack Care Advisors	Professional fees		8,333						
Alpha Data Services	Data Processing		3,249						
Accu-Med	Computer services		1,093						
Personnel Planners	Unemployment tax consultant		1,335				Seminar Expense	1,730	
Barton Management-Allocation	Computer services		4,165						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 35,517				TOTAL	\$ 1,730	

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

## XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. Illinois Council on LTC \$8544 Yes

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period? Yes  
10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 121,545  
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? No

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,564 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees